



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • [www.tdi.texas.gov](http://www.tdi.texas.gov)

## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

SIERRA PROVIDENCE EAST MEDICAL  
6514 MCNEIL DR BLDG 2 STE 201  
AUSTIN TX 78729-7710

#### **Respondent Name**

Wal Mart Associates Inc

#### **Carrier's Austin Representative Box**

Box Number 53

#### **MFDR Tracking Number**

M4-12-1969-01

#### **MFDR Date Received**

February 7, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "The calculation is in accordance with the Medicare approved and audited system."

**Amount in Dispute:** \$1,452.36

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** "System reviews upheld previous payments, with no additional reimbursement allowed."

**Response Submitted by:** Hoffman Kelley, 5316 Hwy. 290 West, Suite 360, Austin, TX 78735

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 4, 2011	Outpatient Hospital Services	\$1,452.36	\$1,365.08

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated June 29, 2011

- 56 – SIGNIFICANT, SEPARATELY IDENTIFIABLE E/M SERVICE RENDERED
- W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
- 802 – CHARGE FOR THIS PROCEDURE EXCEEDS THE OPPTS SCHEDULE ALLOWANCE

- 954 – THE ALLOWANCE FOR NORMALLY PACKAGED REVENUE AND/OR SERVICE CODES HAVE BEEN PAID IN ACCORDANCE WITH THE DISPERSED OUTPATIENT ALLOWANCE.

Explanation of benefits dated October 25, 2011

- 193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. THIS CLAIM WAS PROCESSED PROPERLY THE FIRST TIME
- 1014 – THE ATTACHED BILLING HAS BEEN RE-EVALUATED AT THE REQUEST OF THE PROVIDER. BASED ON THIS RE-EVALUATION, WE FIND OUR ORIGINAL REVIEW TO BE CORRECT. THEREFORE, NO ADDITIONAL ALLOWANCE APPEARS TO BE WARRANTED.

### **Issues**

1. Is the respondent able to bring forward a new reason for denial?
2. What is the applicable rule for determining reimbursement for the disputed services?
3. What is the recommended payment amount for the services in dispute?
4. Is the requestor entitled to reimbursement?

### **Findings**

1. Respondent's position stated "10140 reportable for Incision & Drainage of hematoma INCORRECTLY BILLED BY PROVIDER, on the following bases:
  - Procedure is NOT DOCUMENTED. NO INCISION or any dissection of tissue is documented in complete medical records. As well, NO DRAINAGE OF HEMATOMA is referenced. This procedure customarily requires some level of anesthesia, also not documented.
  - 10140 was correctly NOT BILLED BY PHYSICIAN
  - The billed code 10140 INCISION & DRAINAGE OF HEMATOMA reflects upcoding to a higher complexity level of the DOCUMENTED PROCEDURE, EVACUATION OF SUBUNGUAL HEMATOMA, CPT 11740."

28 Texas Administrative Code §133.307(2)(F) states, "The response shall address only those denial reasons presented to the requestor prior to the date the request for MFDR was filed with the division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." This position was not presented to provider on original explanation of benefits dated June 29, 2011 or re-evaluation dated October 25, 2011. The disputed services will therefore be reviewed per applicable Division rules and fee guidelines.

2. This dispute relates to facility services performed in an outpatient hospital setting with reimbursement subject to the provisions of 28 Texas Administrative Code §134.403, which requires that the reimbursement calculation used for establishing the maximum allowable reimbursement (MAR) shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register with the application of minimal modifications as set forth in the rule. Per §134.403(f)(1), the sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by 200 percent, unless a facility or surgical implant provider requests separate reimbursement of implantables. Review of the submitted documentation finds that separate reimbursement for implantables is not applicable.
3. Under the Medicare Outpatient Prospective Payment System (OPPS), each billed service is assigned an Ambulatory Payment Classification (APC) based on the procedure code used, the supporting documentation and the other services that appear on the bill. A payment rate is established for each APC. Depending on the services provided, hospitals may be paid for more than one APC per encounter. Payment for ancillary and supportive items and services, including services that are billed without procedure codes, is packaged into payment for the primary service. A full list of APCs is published quarterly in the OPPS final rules which are publicly available through the Centers for Medicare and Medicaid Services (CMS) website. Reimbursement for the disputed services is calculated as follows:
  - Procedure code 73140 has a status indicator of X, which denotes ancillary services paid under OPPS with separate APC payment. These services are classified under APC 0260, which, per OPPS Addendum A, has a payment rate of \$45.04. This amount multiplied by 60% yields an unadjusted labor-related amount of \$27.02. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of \$23.12. The non-labor related portion is 40% of the APC rate or \$18.02. The sum of the labor and non-labor related amounts is \$41.14. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$41.14. This amount multiplied by 200% yields a MAR of \$82.28.

- Procedure code 29130 has a status indicator of S, which denotes a significant procedure, not subject to multiple-procedure discounting, paid under OPPS with separate APC payment. These services are classified under APC 0058, which, per OPPS Addendum A, has a payment rate of \$77.15. This amount multiplied by 60% yields an unadjusted labor-related amount of \$46.29. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of \$39.60. The non-labor related portion is 40% of the APC rate or \$30.86. The sum of the labor and non-labor related amounts is \$70.46. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$70.46. This amount multiplied by 200% yields a MAR of \$140.92.
  - Procedure code 10140 has a status indicator of T, which denotes a significant procedure subject to multiple-procedure discounting. The highest paying status T procedure is paid at 100%; all others are paid at 50%. This procedure is paid at 100%. These services are classified under APC 0007, which, per OPPS Addendum A, has a payment rate of \$896.28. This amount multiplied by 60% yields an unadjusted labor-related amount of \$537.77. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of \$460.06. The non-labor related portion is 40% of the APC rate or \$358.51. The sum of the labor and non-labor related amounts is \$818.57. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$818.57. This amount multiplied by 200% yields a MAR of \$1,637.14.
  - Procedure code 99284 has a status indicator of Q3, which denotes conditionally packaged codes that may be paid through a composite APC. If OPPS criteria are met, this service is assigned to composite APC 8003; however, review of the submitted information finds that the criteria for composite payment have not been met. Therefore, this line may be paid separately. This line is assigned status indicator V, which denotes a clinic or emergency department visit paid under OPPS with separate APC payment. These services are classified under APC 0615, which, per OPPS Addendum A, has a payment rate of \$222.58. This amount multiplied by 60% yields an unadjusted labor-related amount of \$133.55. This amount multiplied by the annual wage index for this facility of 0.8555 yields an adjusted labor-related amount of \$114.25. The non-labor related portion is 40% of the APC rate or \$89.03. The sum of the labor and non-labor related amounts is \$203.28. The cost of these services does not exceed the annual fixed-dollar threshold of \$2,025. The outlier payment amount is \$0. The total Medicare facility specific reimbursement amount for this line is \$203.28. This amount multiplied by 200% yields a MAR of \$406.56.
4. The total allowable reimbursement for the services in dispute is \$2,266.90. This amount less the amount previously paid by the insurance carrier of \$901.82 leaves an amount due to the requestor of \$1,365.08. This amount is recommended.

### **Conclusion**

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,365.08.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of \$1,365.08, plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this order.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
May 22, 2013  
Date

### ***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent

to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.**

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**